To accurately complete the NDC codes and amount administered, it will be necessary to look at the actual medications that are given to the resident. For example, some injectable medications can be provided in vials, ampules, or premeasured syringes.

If Section U is completed by the pharmacist or other nursing facility personnel, these persons must certify its accuracy with their signature in AA9, Attestation Statement. The RN Assessment Coordinator must review Section U to ensure that it is complete.

Coding: The coding instructions are extensive. Review them carefully. Study the examples. Complete the coding exercises at the end of this section.

1. Medication Name and Dose Ordered. Identify and record all medications that the resident **received** in the last seven days. Also identify and record any medications that may not have been given in the last seven days, but are part of the resident's regular medication regimen (e.g. monthly B-12 injections). Do **not** record PRN medications that were **not** administered in the last seven days.

Record the name of the medication and dose that was ordered by the physician in column 1. Write the name of the medication and dose ordered *EXACTLY* as it appears on the MAR. For example, if the MAR indicates Acetaminophen 650 mg, **do not** write Acetaminophen 325 mg. 2 tabs, even if two 325mg. tablets are administered to the resident.

Occasionally, dosages of medications may be changed during the 7-Day assessment period. The medication with dosage changes should be recorded separately.

Clarifications:

- Code only medications that the physician orders at the facility. If a facility medication order is carried out off premises, (e.g., a dose administered at a dialysis center), that should be included in Section U. In this example, the facility should be made aware (e.g., via report) of medication administered at the Dialysis Center, but there is no item on the MDS to capture this information. Dialysis itself is captured in P1ab.

- There should be 9 digits in an NDC code. Check or re-check the source of an 8 digit NDC code to see if a zero might have been dropped. Begin recording the code in the leftmost box on the MDS. Many NDC codes begin with one or more zeros. The zeros are important. Do not omit them. Some NDC codes have 11 digits. In this case, disregard the last 2 digits, (they are package size codes).

- Code the NDC for the medication that was administered during the observation period. If during the observation period, both the generic and the brand name medications were administered (under the same order), it's up to the facility to decide which to code. For example, the facility may decide to

routinely code the generic in such instances. Whatever the decision, it should be carried out consistently. Do not code both, a brand and generic name, as it would give the appearance of a double order of the same medication.

- When a medication dosage involves 2 separate NDC codes, (e.g., for a physician's order of Coumadin 3 mg., the pharmacy sends (1) 1 mg and (1) 2 mg tablet), code only the NDC for the highest dose. Record the ordered dose (in this example, 3 mg) in column 1 of Section U.
- When an oral medication is crushed and administered via G-tube, use code 9, enteral tube. A note of caution: some oral medications should not be crushed.
- Stat orders are coded as 1 in the PRN column.
- All medications received by the resident, including over-the-counter medications, should be ordered by the physician and included in Section U.
- Record the total number of doses, not days, in the last 7 days, which the PRN medication was given.

EXAMPLE FOR MEDICATION NAME AND DOSE ORDERED

Medications as listed on MAR for assessment period of 8/11/02-8/17/02

A. Lasix 40 mg. daily p.o.
B. Acetaminophen 325 mg. 2 tabs q3-4 hrs PRN p.o. (given 3 times in last 7 days)
C. B-12 1cc q month IM (given 8/8/02)
D. Isopto Carbachol 1.5% 2 drops OD TID
E. Robitussin-DM 5cc HS PRN p.o. (not given in last 7 days)
F. Motrin 300 mg. QID p.o. (discontinued 8/15/02)
G. Dilantin 300 mg. HS p.o. (ordered 8/15/02)
H. Theo-Dur 200 mg. BID p.o. (given 8/11-8/13/02 and then order discontinued)
I. Theo-Dur 200 mg TID p.o. (given 8/14-8/16/02 and then order discontinued)
J. Theo-Dur 400 mg BID p.o. (given 8/02)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes
Lasix 40 mg.					
Acetaminophen 325 mg. 2 tabs					
B-12 1cc					
Isopto Carbachol 1.5% 2 drops					
Motrin 300 mg.					
Dilantin 300 mg.					
Theo-Dur 200 mg.					
Theo-Dur 200 mg.					
Theo-Dur 400 mg.					

*Note that Robitussin-DM was not recorded because it was not given in the last 7 days.

2. Route of Administration. Determine the Route of Administration (RA) used to administer each medication. The MAR and the physician's orders should identify the RA for each medication. Record the RA in column 2 using the following codes:

1=by mouth (PO)
2=sub lingual (SL)
3=intramuscular (IM)
4=intravenous (IV)
5=subcutaneous (SQ)
6=rectal (R)
7=topical
8=inhalation
9=enteral tube
10=other

EXAMPLE FOR ROUTE OF ADMINISTRATION

Medications as listed on MAR for assessment period of 8/11/02-8/17/02

A. Mylanta 15 cc after meals p.o.
B. Zantac 150 mg. q 12 hrs. Per tube
C. Transderm nitro patch 2.5 1 patch daily
D. NPH 15 U before breakfast daily SQ
E. Lasix 80 mg. IV STAT
G. Acetaminophen suppository 650 mg. q 4 hrs. PRN (given on 2 occasions in last 7 days)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes
Mylanta 15cc	1				
Zantac 150 mg.	9				
Transderm nitro patch 2.5 1 patch	7				
NPH 15 U	5				
Lasix 80 mg.	4				
Acetaminophen suppository 650 mg.	6				

3. Frequency. Determine the number of times per day, week, or month that each medication is given. Record the frequency in column 3 using the following codes:

PR=(PRN) as necessary
1H=(QH) every hour
2H=(Q2H) every two hours
3H=(Q3H) every three hours
4H=(Q4H) every four hours
6H=(Q6H) every six hours
8H=(Q8H) every eight hours
1D=(QD or HS) once daily
2D=(BID) two times daily (includes every 12 hrs)
3D=(TID) three times daily
4D=(QID) four times daily
5D=five times daily
1W=(Q week) once each wk
2W=two times every week
3W=three times every week
QO=every other day
4W=4 times each week
5W=five times each week
6W=six times each week
1M=(Q mo) once every month
2M=twice every month
C=continuous
O=other

Be careful to differentiate between similar frequencies. For example, some nursing facilities have a policy that antibiotics are to be administered around the clock. Therefore, if an antibiotic is ordered as T.I.D., the medication may actually be given q 8 hours. There is a different frequency code for T.I.D. (3D) and q 8 hrs (8H). In this case, the frequency code would be 8H (q 8 hrs.).

If insulin is given on a sliding scale, each different dose of insulin given is entered as a PRN medication.

EXAMPLE FOR FREQUENCY

Medications as listed on MAR for assessment period of 8/11/02-8/17/02

A. Ampicillin 250 mg. q 6 hrs x 10 days p.o. (8/10-8/20)
B. Beconase nasal inhaler 1 puff BID
C. Compazine suppository 5 mg. STAT
D. Lanoxin 0.25 mg. p.o. every other day. On alternate days, give Lanoxin 0.125 mg. p.o.
E. Peri-colace 2 capsules HS p.o.
F. NPH 15 U before breakfast daily SQ
G. Check blood sugar daily at 4 p.m. Sliding scale insulin: NPH 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/02 for BS of 255; 5 units given on 8/13/02 for BS of 233; 10 units given on 8/17/02 for BS of 305)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes
Ampicillin 250 mg.	1	6H			
Beconase nasal inhaler 1 puff	8	2D			
Compazine suppository 5 mg.	6	PR			
Lanoxin 0.25 mg.	1	QO			
Lanoxin 0.125 mg.	1	QO			
Peri-colase 2 capsules	1	1D			
NPH 15 U	5	1D			
NPH 5 U	5	PR			
NPH 10 U	5	PR			

4. Amount Administered (AA). Determine the amount of medication administered each time the medication was given. Amount administered **is not always** the dose. Rather, it is the number of tablets, capsules, suppositories, or amount of liquid (cc's, mls, units) **per dose** that is administered to a resident. For **tablets, capsules or suppositories**, enter the ***number*** of tablets or capsules that were given for each *administration* in column 4 (e.g. 1, 2, 1.5). For **liquids**, enter the ***number*** of cc's, mls, or units that were given for each *administration* in column 4 (e.g. 0. 5 ml, 2.5 cc, 10 units). For **topical medications** (e.g. creams, ointments, eye drops), **inhalation medications**, and **oral medications that are dissolved in water**, enter the numeric code **999** in column 4. If a half of tablet or half of cc is administered, enter it as a decimal (0.5) rather than a fraction.

EXAMPLE FOR AMOUNT ADMINISTERED (AA)

Medications as listed on MAR for assessment period of 8/11/02-8/17/02

A. Lanoxin 0.125 mg. daily p.o.
B. Haldol 1 mg. liquid q8 hrs PRN p.o. (received 2 times in last 7 days)
C. Ampicillin 250 mg. q 6 hrs liquid p.o.
D. Acetaminophen 650 mg. QID p.o. (pharmacy supplies two 325 mg. tablets)
E. Acetaminophen 325 mg. 3 tabs q3-4 hrs PRN for pain p.o. (received 5 times in last 7 days)
F. NPH 15 U before breakfast daily SQ
G. Check blood sugar daily at 4 p.m. Sliding scale insulin: NPH 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/02 for BS of 255; 5 units given on 8/13/02 for BS of 233; 10 units given on 8/17/02 for BS of 305)
H. Elase ointment to necrotic tissue on left heel TID
I. Diazepam 3 mg. HS p.o.
J. Dilantin 300 mg. HS p.o.
K. Metamucil powder 1 tbsp. in a.m. p.o.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes
Lanoxin 0.125 mg.	1	1D	1		
Haldol 1 mg.	1	PR	.5cc		
Ampicillin 250 mg.	1	6H	5ml		
Acetaminophen 650 mg.	1	4D	2		
Acetaminophen 325 mg. 3 tabs	1	PR	3		
NPH 15 U	5	1D	15U		
NPH 5 U	5	PR	5U		
NPH 10 U	5	PR	10U		
Elase ointment	7	3D	999		
Diazepam 3 mg.	1	1D	1.5		
Dilantin 300 mg.	1	1D	3		
Metamucil powder 1 tbsp.	1	1D	999		

5. **PRN-Number of Doses (PRN-n).** The PRN-n column is only completed for medications that have a route of administration coded as PR. Record the **number of times** in the past seven days that each medication coded as PR was given. STAT medications are recorded as a PRN medication. Remember, if a PRN medication was **not** given in the past seven days, it should **not** be listed in Section U.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes
Mylanta 15 cc	1	PR	15cc	12	
Haldol 1 mg.	1	PR	0.5cc	2	
Hydrocortisone cream 1%	7	PR	999	5	
Lasix 80 mg.	4	PR	8cc	1	
NPH 5 Units	5	PR	5U	2	
NPH 10 Units	5	PR	10U	1	
Nitroglycerin 0.3 mg.	2	PR	1	2	

6. National Drug Code (NDC). It is very important that all of the information about the medication (medication name, dose ordered, frequency, and amount administered) corresponds with the NDC code. A medication usually has more than one NDC code. The different types of NDC codes are based on the **strength** of the medication and the **form** of the medication (e.g. solution; tablets, ampules, syringes, ointment, cream, vial, spray, drops). For example, there are 21 NDC codes for morphine. If the resident was receiving 2 mg of morphine IM and the pharmacy sent it in an ampule form, the NDC code is 006411180; if the pharmacy sent the morphine in a vial, the NDC code is 006412343. If your pharmacist is involved in completing this section, the pharmacist would be able to provide the appropriate NDC code.

There will be occasions when a medication dosage will involve two NDC codes. For example, if Coumadin 3 mg. was ordered, the pharmacy would send a 1 mg. tablet and a 2 mg. tablet, each having a different NDC code. In cases such as this, use the NDC code for the largest dose (2 mg).

Code investigational drugs as 999999999. Code compounds (topical mixtures prepared by the pharmacist) as 888888888.

Record the NDC code in column 6. Begin writing in the left hand box entering one digit per box. There should be 9 numbers in the NDC code recorded in column 6. Recheck the number to be sure you have entered the digits correctly. Many NDC codes begin with one or more zeros. These zeros are important; do not omit them. If the NDC codes you are using have eleven (11) digits, disregard the last two digits, as these are the package codes.

EXAMPLE FOR NDC CODES

Medications as listed on MAR for assessment period of 8/11/02-8/17/02

A. Lanoxin 0.125 mg. daily p.o.
B. Haldol 1 mg. liquid q8 hrs PRN p.o. (administered 2 times in last 7 days)
C. Ampicillin 250 mg. q 6 hrs. liquid p.o.
D. Acetaminophen 650 mg. QID p.o. (pharmacy supplies two 325 mg. tablets)
F. NPH 15 U before breakfast daily SQ
G. Check blood sugar daily at 4 p.m. Sliding scale insulin: NPH 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/02 for BS of 255; 5 units given on 8/13/02 for BS of 233; 10 units given on 8/17/02 for BS of 305).
H. Transderm Nitro 1 Patch QD
I. Lasix 80 mg. IV STAT
J. Diazepam 3 mg. HS p.o.
K. Dilantin 300 mg. HS p.o.

1. Medication Name and Dose Ordered	2.RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes
Lanoxin 0.125 mg.	1	1D	1		0 0 0 8 1 0 2 4 2
Haldol 1 mg.	1	PR	.5cc	2	0 0 0 4 5 0 2 5 0
Ampicillin 250 mg.	1	6H	5ml		0 0 0 4 7 2 3 0 2
Acetaminophen 650 mg.	1	4D	2		0 0 7 8 1 1 2 9 4
NPH 15 U	5	1D	15U		0 0 0 0 2 8 3 1 5
NPH 5 U	5	PR	5U	2	0 0 0 0 2 8 2 1 5
NPH 10 U	5	PR	10U	1	0 0 0 0 2 8 2 1 5
Transderm Nitro 1 patch	7	1D	999		0 0 0 8 3 2 0 2 5
Lasix 80 mg.	4	PR	8cc	1	0 0 0 3 9 0 0 6 3
Diazepam 3 mg.	1	1D	1.5		0 0 3 6 4 0 7 7 4
Dilantin 300 mg.	1	1D	3		0 0 0 7 1 0 3 6 2

Coding Exercises for Section U

Complete Section U for the following medications during a 7-day period (9/1/02-9/7/02):

1. Inderal 40 mg. BID p.o.
2. Sinemet 10/100 TID p.o.
3. Artificial Tears 1 drop OU QID
4. Anusol HC suppository 1 PRN (given 1 time in last 7 days)
5. Amoxicillin 500 mg q 6 hrs per tube
6. Benylin cough syrup 2 tbs. PRN p.o. (given 10 times in last 7 days)
7. Darvocet-N 100 2 tabs q 4-6 hrs PRN p.o. (given 5 times in last 7 days)
8. Heparin lock flush 10 U daily
9. Ditropan syrup 2.5 mg daily p.o.
10. Nitrotransdermal .4 mg 1 patch daily
11. Novolin N 24 U before breakfast SQ
12. Check blood sugar before breakfast. Sliding scale insulin: Novolin R 10 units if blood sugar over 200. (10 units given on 2 days in last 7 days)
13. Questran 1 packet with each meal p.o.
14. Quinine sulfate 325 mg. HS
15. Coumadin 2.5 mg daily p.o. (discontinued 9/3/02)
16. Coumadin 5 mg. daily p.o. (ordered to start on 9/4/02)
17. Maalox 15 cc PRN for indigestion p.o. (not administered in last 7 days)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes							

Compare your responses to the coding exercises with the responses on the next page.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes
Inderal 40 mg.	1	2D	1		0 0 0 4 6 0 4 2 4
Sinemet 10/100	1	3D	1		0 0 0 0 6 0 6 4 7
Artificial Tears 1 drop	7	4D	999		0 0 3 4 9 8 6 1 5
Anusol HC suppository 1	6	PR	1	1	0 0 0 7 1 1 0 8 8
Amoxicillin 500 mg.	9	6H	10 ml		0 0 3 0 4 0 5 8 7
Benylin cough syrup 2 Tbs.	1	PR	30 cc	10	0 0 0 7 1 2 1 9 5
Darvocet-N 100 2 tabs	1	PR	2	5	0 0 0 0 2 0 3 6 3
Heparin lock flush 10 U	4	1D	1 ml		0 0 4 6 9 3 0 0 1
Ditropan syrup 2.5 mg	1	1D	2.5ml		0 0 0 8 8 1 3 7 3
Nitrotransdermal .4 mg.	7	1D	999		4 7 2 0 2 2 8 3 2
Novolin N 24 U	5	1D	24 U		0 0 0 0 3 1 8 3 4
Novolin R 10 U	5	PR	10 U	2	0 0 0 0 3 1 8 3 3
Questran 1 packet	1	3D	999		0 0 0 8 7 0 5 8 0
Quinine sulfate 325 mg.	1	1D	1		0 0 0 0 2 0 6 2 9
Coumadin 2.5 mg.	1	1D	1		0 0 0 5 6 0 1 7 6
Coumadin 5 mg.	1	1D	1		0 0 0 5 6 0 1 7 2

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

The MDS alone does not provide a comprehensive assessment. Rather, the MDS is used for preliminary screening to identify potential resident problems, strengths, and preferences. The RAPs are problem-oriented frameworks for additional assessment based on problem identification items (triggered conditions). They form a critical link to decisions about care planning. The RAP Guidelines provide guidance on how to synthesize assessment information within a comprehensive assessment. The Triggers target conditions for additional assessment and review, as warranted by MDS item responses; the RAP Guidelines help facility staff evaluate "triggered" conditions.

There are 18 RAPs in Version 2.0 of the RAI. The RAPs in the RAI cover the majority of areas that are addressed in a typical nursing facility resident's care plan.

Following completion of the MDS and review of the triggered RAPs, a decision is made by the interdisciplinary team to proceed to care planning for each of the triggered RAPs. The RAPs were created by clinical experts in each of the RAP areas. Chapter 4 provides detailed instructions on the RAP and care planning process.

The MDS identifies actual or potential problem areas. The RAPs provide further assessment of the "triggered" areas; they help staff to look for causal or confounding factors (some of which may be reversible). Use the RAPs to analyze assessment findings and then "chart your thinking." It is important that the RAP documentation include the causal or unique risk factors for decline or lack of improvement. The plan of care then addresses these factors with the goal of promoting the resident's highest practicable level of functioning: 1) improvement where possible, or 2) maintenance and prevention of avoidable declines.

A. RAP Problem Area

Purpose: The RAP Summary documents the decisions from the interdisciplinary team on which of the "triggered" conditions will be addressed in the care plan.

Process: Facility staff use the RAI triggering mechanism to determine which RAP problem areas require review and additional assessment. The triggered conditions are indicated in the appropriate column (VAa) on the RAP Summary form. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.

Describe:

- Nature of the condition (may include presence or lack of objective data and subjective complaints).

- Complications and risk factors that affect your decision to proceed to care planning.
- Factors that must be considered in developing individualized care plan interventions.
- Need for referrals/further evaluation by appropriate health professionals.
- Documentation should support your decision-making regarding whether or not to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
- Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
- Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.

Coding: For each triggered RAP, indicate whether or not a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment (VAb). The Care Planning Decision column must be completed within 7 days of completing the RAI as indicated by the date in VB2 (RAPs Completion Date).

B. Signature and Completion Dates

VB1: Signature of the RN coordinating the RAP assessment process.

VB2: Date that the RN coordinating the RAP assessment process certifies that the RAPs have been completed. The RAP review must be completed no later than day 14 from the admission date for an Admission assessment and within 14 days of the Assessment Reference Date (A3a) for an Annual assessment, Significant Change in Status assessment, or a Significant Correction of a Prior Full assessment. This date is considered the date of completion for the RAI (i.e., the date used to determine compliance with Federal time frames for assessment and the date that drives future due dates for when the RAI needs to be completed).

VB3: Signature of the staff person facilitating the care planning decision-making. It does not have to be an RN.

VB4: The date on which a staff member completes the care planning decision column (VAb), which is done after the care plan is completed. The care plan must be completed within 7 days of the completion of the comprehensive assessment (MDS and RAPs) as indicated by the date in VB2.

Following completion of the care plan, the MDS, triggers (VAa), and care planning decisions (VAb) must be transmitted to the MDS State database within 31 days of the VB4 date.

Clarifications: ◆ The signatures at VB1 and VB3 can be the same person, provided that person actually completed both functions. It is not a requirement that the same person complete both.

- If a resident is discharged prior to the completion of Section V, a comprehensive assessment may be in progress when a resident is discharged. Even though the resident has been discharged, the facility may complete and submit the assessment. The following guidelines apply to completing a comprehensive assessment when the resident has been discharged:

  (1) Complete all required MDS items from Section AA through Section U (as they apply in your state) and indicate the date of completion in R2b. Encode and verify these items.

  (2) Complete the RAPs (Section V, Column A) and code whether each was triggered or not (VAa).

  (3) Enter the date the RAP triggers were computed at VB2.

  (4) Dash fill all of the care planning decision items in Section VAb (indicating that the decisions are unknown).

  (5) Enter the same date in VB4 as was used in VB2.

  (6) Submit the record.